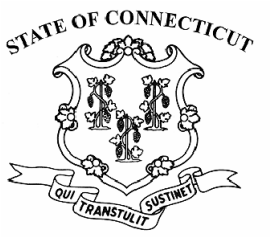

Senate

General Assembly

File No. 392

January Session, 2013

Substitute Senate Bill No. 1093

Senate, April 8, 2013

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING REVISIONS TO THE INSURANCE STATUTES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsection (d) of section 38a-8 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(d) The commissioner shall develop a program of periodic review to ensure compliance by the Insurance Department with the minimum standards established by the National Association of Insurance Commissioners for effective financial surveillance and regulation of insurance companies operating in this state. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, pertaining to the financial surveillance and solvency regulation of insurance companies and health care centers as are reasonable and necessary to obtain or maintain the accreditation of the Insurance Department by the National Association of Insurance Commissioners. The commissioner shall maintain **[**,**]** as confidential **[**,**]** any confidential documents or information received from the National Association of

Insurance Commissioners, **[**or**]** the International Association of Insurance Supervisors, the Bank for International Settlements or the Federal Insurance Office, or any documents or information received from state or federal insurance, banking or securities regulators or similar regulators in a foreign country **[**which**]** that are confidential in such jurisdictions. The commissioner may share any information, including confidential information, with the National Association of Insurance Commissioners, the International Association of Insurance Supervisors, the Bank for International Settlements or the Federal Insurance Office, or state or federal insurance, banking or securities regulators or similar regulators in a foreign country, **[**so long as**]** provided the commissioner determines that such entities agree to maintain the same level of confidentiality in their **[**jurisdiction**]** jurisdictions as is available in this state. **[**The**]** At the expense of a domestic, alien or foreign insurer, the commissioner may engage the services of **[**, at the expense of a domestic, alien or foreign insurer,**]** attorneys, actuaries, accountants and other experts not otherwise part of the commissioner's staff as may be necessary to assist the commissioner in the financial analysis of the insurer, the review of the insurer's license applications, and the review of transactions within a holding company system involving an insurer domiciled in this state. No duties of a person employed by the Insurance Department on November 1, 2002, shall be performed by such attorney, actuary, accountant or expert.

Sec. 2. Subsection (e) of section 38a-14 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(e) (1) Nothing contained in this section shall be construed to limit the commissioner's authority to terminate or suspend any examination in order to pursue legal or regulatory action pursuant to the insurance laws of this state. Findings of fact and conclusions made pursuant to any examination shall be prima facie evidence in any legal or regulatory action.

(2) Nothing contained in this section shall be construed to limit the commissioner's authority in such legal or regulatory action to use and, if appropriate, to make public any final or preliminary examination report, any examiner or company workpapers or other documents, or any other information discovered or developed during the course of any examination.

(3) Not later than sixty days following completion of the examination, the examiner in charge shall file, under oath, with the Insurance Department a verified written report of examination. Upon receipt of the verified report, the Insurance Department shall transmit the report to the **[**company**]** entity examined, together with a notice **[**which**]** that shall afford the **[**company**]** entity examined a reasonable opportunity, not to exceed thirty days, to make a written submission or rebuttal with respect to any matters contained in the examination report. Not later than thirty days after the period allowed for the receipt of written submissions or rebuttals, the commissioner shall fully consider and review the report, together with any written submissions or rebuttals and any relevant portions of the examiner's workpapers and enter an order: (A) Adopting the examination report as filed or with modification or corrections. If the examination report reveals that the **[**company**]** entity is operating in violation of any law, regulation or prior order of the commissioner, the commissioner may order the company to take any action the commissioner considers necessary and appropriate to cure such violation; (B) rejecting the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation or information, and refiling pursuant to **[**subparagraph (A) of**]** this subdivision; or (C) calling for an investigatory hearing with not less than twenty days' notice to the company for purposes of obtaining additional documentation, data, information and testimony.

(4) (A) The commissioner shall transmit the examination report adopted pursuant to subparagraph (A) of subdivision (3) of this subsection or a summary thereof to the entity examined, together with any recommendations or written statements from the commissioner or

the examiner. The secretary of the board of directors or similar governing body of the entity shall provide a copy of the report or summary to each director and shall certify to the commissioner, in writing, that a copy of the report or summary has been provided to each director.

(B) Not later than ninety days after receiving the report or summary, the chief executive officer of the entity examined shall present the report or summary to the entity's board of directors or similar governing body at a regular or special meeting.

Sec. 3. Subsection (e) of section 38a-53 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(e) Any insurance company or health care center doing business in this state **[**which**]** that fails to file any report or statement required under this section shall pay a late filing fee of one hundred seventy-five dollars per day for each day from the due date of such report or statement to the date of filing. The commissioner may waive the late filing fee if (1) the insurance company or health care center cannot file such report or statement because the Governor of such company's or health care center's state of domicile has proclaimed a state of emergency in such state and such state of emergency impairs the company's or health care center's ability to file the report or statement, or (2) the insurance regulatory official of the state of domicile of a foreign insurance company has permitted the company, or the commissioner has permitted a health care center, to file such report or statement late.

Sec. 4. Subsection (a) of section 38a-58a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a) Any insurer **[**which**]** that is organized under the laws of any other state and is admitted to do business in this state for the purpose of writing insurance and any alien captive insurance company, as

defined in section 38a-91aa, may become a domestic insurer by complying with all of the requirements of law relative to the organization and licensing of a domestic insurer of the same type and by designating its principal place of business at a location in this state. The domestic insurer shall be entitled to like certificates and licenses to transact business in this state and shall be subject to the authority and jurisdiction of this state. The articles of incorporation of the domestic insurer may be amended to provide that the corporation is a continuation of the corporate existence of the original foreign corporation through adoption of this state as its corporate domicile and that the original date of incorporation in its original domiciliary state is the date of incorporation of the domestic insurer.

Sec. 5. Subdivision (5) of subsection (a) of section 38a-91bb of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(5) No captive insurance company may provide personal risk insurance, as defined in section 38a-663, for private passenger motor vehicle or homeowners insurance coverage or any component thereof;

Sec. 6. Subsection (e) of section 38a-91ff of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(e) **[**A branch captive insurance company may be established in this state to write in this state only insurance or reinsurance of the employee benefit business of its parent and affiliated companies that is subject to the Employee Retirement Income Security Act of 1974, as amended from time to time.**]** No branch captive insurance company shall do any insurance business in this state unless it maintains **[**the principal**]** a place of business for its **[**branch**]** operations in this state.

Sec. 7. Subsection (n) of section 38a-91ff of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(n) The provisions of this chapter pertaining to mergers, consolidations, [and] conversions and transfers of domicile shall apply in determining the procedures to be followed by captive insurance companies in carrying out any of the transactions described in this chapter.

Sec. 8. Subsection (b) of section 38a-91kk of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(b) A captive insurance company may only take credit for the reinsurance of risks or portions of risks ceded to reinsurers that [complies] comply with the provisions of [section] sections 38a-85 [or 38a-86] to 38a-88, inclusive, unless the commissioner has given prior written approval allowing the captive insurance company to take credit for the reinsurance of risks or portions of risks ceded to reinsurers that do not comply with the provisions of sections 38a-85 to 38a-88, inclusive.

Sec. 9. Section 38a-91oo of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a) Unless otherwise provided in sections 38a-91aa to 38a-91tt, inclusive, no provision of this title shall apply to captive insurance companies, unless expressly included therein, except for the following: [(1)] Sections 38a-8, as amended by this act, 38a-16, 38a-17, 38a-54 to [38a-57, inclusive,] 38a-59, inclusive, 38a-69a, [38a-129 to 38a-140, inclusive, and] 38a-102h and 38a-250 to 38a-266, inclusive, and chapter 704c. [; and (2) section]

(b) Sections 38a-73 [which] and 38a-129 to 38a-140, inclusive, shall apply [only] to captive insurance companies formed as risk retention groups, as defined in section 38a-91aa.

(c) The commissioner may adopt regulations, in accordance with the provisions of chapter 54, to establish the circumstances under which a captive insurance company will be required to comply with the

provisions of sections 38a-73 and 38a-129 to 38a-140, inclusive.

Sec. 10. Subsection (b) of section 38a-162 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(b) All licenses issued under the provisions of sections 38a-160 to 38a-170, inclusive, shall expire on the thirtieth day of June following the date of their issuance. At the time of application for an insurance premium finance company license and for every annual renewal thereof there shall be paid to the commissioner the sum of **[**fifty**]** three hundred dollars. If a license is not issued the fee shall be returned.

Sec. 11. Subsection (a) of section 38a-163 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a) Each applicant for an insurance premium finance company license or for any renewal of such license shall file with the commissioner a written application in such manner and form as the commissioner shall prescribe together with **[**said fee of fifty dollars which fee shall be returned to the applicant if such license is not granted**]** the fee specified in subsection (b) of section 38a-162, as amended by this act.

Sec. 12. Section 38a-188 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

Each health care center governed by sections 38a-175 to 38a-192, inclusive, shall be exempt from the provisions of the general statutes relating to insurance in the conduct of its operations under said sections and in such other activities as do constitute the business of insurance, unless expressly included therein, and except for the following: Sections 38a-11, 38a-14a, 38a-17, 38a-51, 38a-52, 38a-56, 38a-57, 38a-129 to 38a-140, inclusive, 38a-147 and 38a-815 to 38a-819, inclusive, provided a health care center shall not be deemed in violation of sections 38a-815 to 38a-819, inclusive, solely by virtue of

such center selectively contracting with certain providers in one or more specialties, and sections 38a-80, 38a-492b, 38a-518b, 38a-543, 38a-702j, 38a-703 to 38a-718, inclusive, 38a-731 to 38a-735, inclusive, 38a-741 to 38a-745, inclusive, as amended by this act, 38a-769, 38a-770, 38a-772 to 38a-776, inclusive, 38a-786, 38a-790, 38a-792 and 38a-794, provided a health care center organized as a nonprofit, nonstock corporation shall be exempt from sections 38a-146, 38a-702j, 38a-703 to 38a-718, inclusive, 38a-731 to 38a-735, inclusive, 38a-741 to 38a-745, inclusive, as amended by this act, 38a-769, 38a-770, 38a-772 to 38a-776, inclusive, 38a-786, 38a-790, 38a-792 and 38a-794. If a health care center is operated as a line of business, the foregoing provisions shall, where possible, be applied only to that line of business and not to the organization as a whole. The commissioner may adopt regulations, in accordance with chapter 54, stating the circumstances under which the resources of a person which controls a health care center, or operates a health care center as a line of business will be considered in evaluating the financial condition of a health care center. Such regulations, if adopted, shall require as a condition to the consideration of the resources of such person which controls a health care center, or operates a health care center as a line of business to provide satisfactory assurances to the commissioner that such person will assume the financial obligations of the health care center. During the period prior to the effective date of regulations issued under this section, the commissioner shall, upon request, consider the resources of a person which controls a health care center, or operates a health care center as a line of business, if the commissioner receives satisfactory assurances from such person that it will assume the financial obligations of the health care center and determines that such person meets such other requirements as the commissioner determines are necessary. A health care center organized as a nonprofit, nonstock corporation shall be exempt from the sales and use tax and all property of each such corporation shall be exempt from state, district and municipal taxes. Each corporation governed by sections 38a-175 to 38a-192, inclusive, shall be subject to the provisions of sections 38a-903 to 38a-961, inclusive. Nothing in this section shall be construed to

override contractual and delivery system arrangements governing a health care center's provider relationships.

Sec. 13. Subsection (e) of section 38a-363 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(e) "Private passenger motor vehicle" means a: (1) Private passenger type automobile; (2) station-wagon-type automobile; (3) camper-type motor vehicle; (4) high-mileage-type motor vehicle, as defined in section 14-1; (5) truck-type motor vehicle with a load capacity of fifteen hundred pounds or less, registered as a passenger motor vehicle, as defined in said section 14-1, or as a passenger and commercial motor vehicle, as defined in said section 14-1, or used for farming purposes; or (6) a vehicle with a commercial registration, as defined in **[**subdivision (12) of**]** said section 14-1. It does not include a motorcycle or motor vehicle used as a public or livery conveyance.

Sec. 14. Section 38a-483b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

Except as otherwise provided in this title, each insurer, health care center, hospital service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, amending or continuing any individual health insurance policy in this state providing coverage of the type specified in subdivisions (1), (2), (4), (11)**,** **[**and**]** (12) and (16) of section 38a-469 shall complete any coverage determination with respect to such policy and notify the insured or the insured's health care provider of its decision not later than forty-five days for claims filed in paper format and twenty days for claims filed in electronic format after a request for such determination is received by the insurer, health care center, hospital service corporation, medical service corporation or other entity. In the case of a denial of coverage, such entity shall notify the insured and the insured's health care provider of the reasons for such denial. If the reasons for such denial include that the requested service is not medically necessary or is not a covered benefit under such policy, the entity shall (1) notify the

insured that such insured may contact the Office of the Healthcare Advocate if the insured believes the insured has been given erroneous information, and (2) provide to such insured the contact information for said office.

Sec. 15. Section 38a-513a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

Except as otherwise provided in this title, each insurer, health care center, hospital service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, amending or continuing any group health insurance policy in this state providing coverage of the type specified in subdivisions (1), (2), (4), (11), **[**and**]** (12) and (16) of section 38a-469 shall complete any coverage determination with respect to such policy and notify the insured or the insured's health care provider of its decision not later than forty-five days for claims filed in paper format and twenty days for claims filed in electronic format after a request for such determination is received by the insurer, health care center, hospital service corporation, medical service corporation or other entity. In the case of a denial of coverage, such entity shall notify the insured and the insured's health care provider of the reasons for such denial. If the reasons for such denial include that the requested service is not medically necessary or is not a covered benefit under such policy, the entity shall (1) notify the insured that such insured may contact the Office of the Healthcare Advocate if the insured believes the insured has been given erroneous information, and (2) provide to such insured the contact information for said office.

Sec. 16. Subdivision (3) of subsection (k) of section 38a-660 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(3) There is established an account to be known as the "surety bail bond agent examination account", which shall be a separate, nonlapsing account within the Insurance Fund established under section 38a-52a. The account shall contain any moneys required by law

to be deposited in the account and any such moneys remaining in the account at the **[**close of the fiscal**]** end of each calendar year shall be transferred to the General Fund.

Sec. 17. Subdivision (11) of section 38a-720 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(11) "Third-party administrator" means any person who directly or indirectly underwrites, collects premiums or charges from, or adjusts or settles claims on, residents of this state in connection with life, annuity or health coverage. **[**offered or provided by an insurer.**]** "Third-party administrator" does not include:

(A) An employer administering its employee benefit plan or the benefit plan of an affiliated employer under common management and control;

(B) A union administering a benefit plan on behalf of its members;

(C) An insurer that is licensed in this state or is acting as an authorized insurer with respect to insurance lawfully issued to cover a Connecticut resident, and sales representatives thereof;

(D) An insurance producer who is licensed to sell life, annuity or health coverage in this state, whose activities are limited exclusively to the sale of insurance;

(E) A creditor acting on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors;

(F) A trust and its trustees, agents and employees acting pursuant to such trust established in conformity with 29 USC Section 186, as amended from time to time;

(G) A trust exempt from taxation under Section 501(a) of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to

time, and its trustees and employees acting pursuant to such trust, or a custodian and the custodian's agents and employees acting pursuant to a custodian account that meets the requirements of Section 401(f) of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time;

(H) A credit union or a financial institution that is subject to supervision or examination by federal or state banking authorities, or a mortgage lender, to the extent such credit union, financial institution or mortgage lender collects or remits premiums to licensed insurance producers or limited lines producers or to authorized insurers, in connection with loan payments;

(I) A credit card issuing company that advances or collects premiums or charges from its credit cardholders who have authorized collection;

(J) An attorney-at-law who adjusts or settles claims in the normal course of such attorney's practice or employment and who does not collect premiums or charges in connection with life, annuity or health coverage;

(K) An adjuster who is licensed in this state or is not subject to the licensure requirements of chapter 702 and whose activities are limited to adjusting claims;

(L) An insurance producer who is licensed in this state and acting as a managing general agent, as defined in section 38a-90a, whose activities are limited exclusively to those specified in said section;

(M) A business entity that is affiliated with an insurer licensed in this state and that undertakes activities as a third-party administrator only for the direct and assumed insurance business of the affiliated insurer;

(N) A consortium of federally qualified health centers funded by the state, providing services only to the recipients of programs

administered by the Department of Social Services;

(O) A pharmacy benefits manager registered under section 38a-479bbb;

(P) An entity providing administrative services to the Health Reinsurance Association established under section 38a-556; or

(Q) A nonprofit association or one of its direct subsidiaries that provides access to insurance as part of the benefits or services such association or subsidiary makes available to its members.

Sec. 18. Subsection (b) of section 38a-720a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) (1) Any insurer licensed in this state that **[**directly or indirectly underwrites, collects premiums or charges from, or adjusts or settles claims for other than its policyholders, subscribers and certificate holders**]** also acts as a third-party administrator shall be exempt from subsections (c) to (e), inclusive, of this section and sections **[**38a-720**]** 38a-720b to 38a-720n, inclusive, provided such activities extend only **[**involve the lines of insurance**]** to life, annuity or health coverage for which such **[**insurer**]** entity is licensed as an insurer in this state. Any such **[**insurer**]** entity shall (A) be subject to the provisions of chapter 704, (B) respond to all complaint inquiries received from the Insurance Department, not later than ten calendar days after the date a complaint is received by the insurer, and (C) with respect to any advertising that mentions any customer, obtain such customer's prior written consent.

(2) Nothing in this section shall authorize the commissioner to regulate a self-insured health plan subject to the Employee Retirement Income Security Act of 1974. The commissioner is authorized to regulate those activities an insurer, acting as a third-party administrator, undertakes for the administration of a self-insured health plan that do not relate to the health benefit plan and that comport with the commissioner's statutory authority to regulate

insurance and the business of insurance as provided for in 29 USC 1144, as amended from time to time.

Sec. 19. Subdivision (1) of subsection (b) of section 38a-741 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) (1) When any policy of insurance is procured under the authority of such license providing a line of insurance or its component that does not, on the effective date of coverage, appear on the current published list, both the licensee and the insured shall execute affidavits setting forth facts showing that such licensee and such insured were unable after diligent effort to procure, from any authorized insurer or insurers, the full amount of insurance required to protect the interest of such insured, and further showing that the amount of insurance procured from an unauthorized insurer or insurers is only the excess over the amount so procurable from authorized insurers. Such licensee shall file such affidavits in electronic format with the commissioner **[**not later than forty-five days after such policies have been procured**]** on February first, May first, August first and November first of each year.

Sec. 20. Subsection (f) of section 38a-860 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(f) (1) Sections 38a-858 to 38a-875, inclusive, shall provide coverage to the persons specified in subsections (a) to (d), inclusive, of this section for direct, nongroup life, health or annuity policies or contracts and supplemental contracts to such policies or contracts, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by said sections. Annuity contracts and certificates under group annuity contracts include, but are not limited to, guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement annuities, annuities issued to or in connection with government

lotteries and any immediate or deferred annuity contracts. (2) Said sections 38a-858 to 38a-875, inclusive, shall not provide coverage for: (A) Any portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract holder; (B) any policy or contract of reinsurance, unless assumption certificates have been issued; (C) any portion of a policy or contract to the extent that the rate of interest on which it is based or the interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value (i) averaged over the period of four years prior to the date on which the member insurer becomes an impaired or insolvent insurer under sections 38a-858 to 38a-875, inclusive, exceeds the rate of interest determined by subtracting two percentage points from Moody's corporate bond yield average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four years before the member insurer becomes an impaired or insolvent insurer under sections 38a-858 to 38a-875, inclusive, whichever is earlier; and (ii) on and after the date on which the member insurer becomes an impaired or insolvent insurer under sections 38a-858 to 38a-875, inclusive, whichever is earlier, exceeds the rate of interest determined by subtracting three percentage points from Moody's corporate bond yield average as most recently available; (D) a portion of a policy or contract issued to any plan or program of an employer, association or similar entity to provide life, health or annuity benefits to its employees or members to the extent that such plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association or similar entity under (i) a multiple employer welfare arrangement as defined in Section 514 of the federal Employee Retirement Income Security Act of 1974, as amended from time to time; (ii) a minimum premium group insurance plan; or (iii) an administrative services only contract; (E) any stop-loss or excess loss insurance policy or contract providing for the indemnification of or payment to a policy owner, a contract owner, a plan or another person obligated to pay life, health or annuity benefits; (F) any portion of a

policy or contract to the extent that it provides dividends, experience rating credits, voting rights or provides that any fees or allowances be paid to any person, including, but not limited to, the policy or contract holder, in connection with the service to or administration of such policy or contract; (G) any policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue such policy or contract in this state; (H) any unallocated annuity contract issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation, regardless of whether the federal Pension Benefit Guaranty Corporation has yet become liable to make any payments with respect to the benefit plan; (I) any portion of an unallocated annuity contract that is not issued to, or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery; (J) any subscriber contract issued by a health care center; (K) a contractual agreement that establishes the insurer's obligation by reference to a portfolio of assets that is not owned or possessed by the insurance company; (L) an obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner or policy owner, including, but not limited to: (i) A claim based on marketing materials; (ii) a claim based on side letters, riders or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements; (iii) a misrepresentation of or regarding policy benefits; (iv) an extra-contractual claim; or (v) a claim for penalties or consequential or incidental damages; (M) a contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer; **[**and**]** (N) a portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the

date the member insurer becomes an impaired or insolvent insurer under sections 38a-858 to 38a-875, inclusive, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this subparagraph, the interest or change in value determined by using the procedures defined in the policy or contract shall be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and shall not be subject to forfeiture; and (O) any policy or contract providing hospital, medical, prescription drugs or other health care benefits pursuant to Part C or Part D of Subchapter XVIII of 42 USC 7, as amended from time to time, or any regulations issued thereunder.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	38a-8(d)
Sec. 2	*October 1, 2013*	38a-14(e)
Sec. 3	*October 1, 2013*	38a-53(e)
Sec. 4	*October 1, 2013*	38a-58a(a)
Sec. 5	*October 1, 2013*	38a-91bb(a)(5)
Sec. 6	*October 1, 2013*	38a-91ff(e)
Sec. 7	*October 1, 2013*	38a-91ff(n)
Sec. 8	*October 1, 2013*	38a-91kk(b)
Sec. 9	*October 1, 2013*	38a-91oo
Sec. 10	*October 1, 2013*	38a-162(b)
Sec. 11	*October 1, 2013*	38a-163(a)
Sec. 12	*October 1, 2013*	38a-188
Sec. 13	*October 1, 2013*	38a-363(e)
Sec. 14	*October 1, 2013*	38a-483b
Sec. 15	*October 1, 2013*	38a-513a
Sec. 16	*from passage*	38a-660(k)(3)
Sec. 17	*from passage*	38a-720(11)
Sec. 18	*from passage*	38a-720a(b)
Sec. 19	*from passage*	38a-741(b)(1)
Sec. 20	*October 1, 2013*	38a-860(f)

INS *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

This bill makes several revisions to the Insurance statutes. There is no state or municipal fiscal impact.

The Out Years

State Impact: None

Municipal Impact: None

OLR Bill Analysis

sSB 1093

AN ACT CONCERNING REVISIONS TO THE INSURANCE STATUTES.

SUMMARY:

This bill revises various insurance statutes, as detailed in the section-by-section analysis below. Among other things, it:

1. allows the insurance commissioner to share and receive confidential information with and from the Federal Insurance Office and the Bank for International Settlements;

2. requires an insurer's or health care center's (HMO) board of directors to receive and review financial examination reports from the commissioner;

3. updates the captive insurance statutes to permit captive companies flexibility to relocate to Connecticut; and

4. reduces, from 45 to 20 days, the timeframe insurers and HMOs have to make coverage determinations for claims submitted electronically.

The bill also makes technical and conforming changes.

EFFECTIVE DATE: Upon passage, except as otherwise noted below.

§ 1—CONFIDENTIAL INFORMATION

The bill allows the insurance commissioner to receive and share confidential information from and with the Federal Insurance Office, which was created under the federal Dodd-Frank Act, and the Bank for

International Settlements, an international organization that fosters international monetary and financial cooperation and serves as a bank for central banks. By law, the commissioner may already receive and share confidential information from and with (1) these groups relative to examinations and (2) the National Association of Insurance Commissioners and the International Association of Insurance Supervisors.

§ 2—FINANCIAL EXAMINATION REPORTS

By law, the insurance commissioner may conduct financial examinations of insurers, HMOs, and similar entities doing business in Connecticut.

The bill requires the insurance commissioner to provide an examination report to the examined entity, along with any recommendations or written statements from the commissioner or examiner. The entity's board of director's secretary must (1) give a report copy or summary to each director and (2) certify to the commissioner in writing that this has occurred.

The bill also requires the examined entity's chief executive officer, within 90 days after receiving the report or summary, to present it to the board of directors at a regular or special meeting.

EFFECTIVE DATE: October 1, 2013

§ 3—LATE FILING FEE

By law, if an insurer or HMO files an annual or quarterly financial statement with the insurance commissioner past its due date, the commissioner fines the entity $175 for every day it is late.

The bill allows the commissioner to waive the late filing fee if (1) the entity cannot file the statement because the governor of its home state proclaimed a state of emergency that prevents the entity from filing it or (2) the entity's home state regulatory official has allowed the entity to file it late.

EFFECTIVE DATE: October 1, 2013

§§ 4-9—CAPTIVE INSURERS

The law allows a captive insurer to be licensed and domiciled in Connecticut to transact life insurance, annuity, health insurance, and commercial risk insurance business. A captive insurer is, in its simplest form, an insurer that is a wholly-owned subsidiary whose primary function is to insure all or part of the risks of its parent company.

Transfer of Domicile (§§ 4, 7, & 9)

The bill allows (1) alien captive insurers (i.e., those formed under the jurisdiction of a foreign country) to relocate to Connecticut without being an admitted insurer and (2) captive insurers to change their domicile (home state) as other insurers are permitted to do by applying existing laws concerning transfer of domicile to captive insurers.

The bill authorizes the insurance commissioner to adopt regulations to establish the circumstances under which the laws concerning acquisition of controlling interest apply to captives. It narrows the applicability of these laws to risk retention captives, instead of all captives.

Personal Lines Limitation (§ 5)

Under current law, no captive can write private passenger motor vehicle or homeowners insurance. The bill narrows this prohibition, stating that no captive can write personal risk insurance for private passenger motor vehicle or homeowners insurance. Thus, a captive can write commercial risk insurance business, including commercial motor vehicle insurance.

Branch Captive (§ 6)

The bill eliminates a provision that limits branch captives to writing only the employee benefits business of its parent and affiliated companies.

Under current law, a branch captive insurer cannot do insurance business in Connecticut unless it maintains its principal place of business here. The bill relaxes the requirement, requiring that the insurer only maintain a place of business here.

By law, a branch captive is any alien captive insurer the commissioner licenses to transact business in Connecticut.

Credit for Reinsurance (§ 8)

By law, a captive can reinsure another insurer's risks, but only those risks the captive is authorized to insure directly. It can also take credit as an asset or deduction from liability for ceding risks to certain reinsurers. The bill allows the commissioner to approve, in writing, credit for reinsurance in other circumstances.

EFFECTIVE DATE: October 1, 2013

§§ 10-11—PREMIUM FINANCE COMPANY LICENSE FEE

The bill increases, from $50 to $300, the application and annual renewal fees for an insurance premium finance company license. Engaging in such business without a license is punishable by up to one year in prison, up to a $2,000 fine, or both.

EFFECTIVE DATE: October 1, 2013

§ 12—HMO FINANCIAL EXAMINATION

By law, the insurance commissioner can examine an HMO's financial condition. The bill allows the commissioner to order an HMO to produce books, records, or other information necessary for him to conduct the examination. The HMO must pay for any such examination.

EFFECTIVE DATE: October 1, 2013

§§ 14-15—TIME LIMITS FOR COVERAGE DETERMINATIONS

By law, insurers, HMOs, and similar entities that deliver, issue, renew, amend, or continue in Connecticut individual or group health

insurance policies must make coverage determinations and notify the insured person or the health care provider within 45 days after receiving a claim.

The bill retains the 45-day requirement for claims filed in paper format, but reduces the timeframe to 20 days for electronically filed claims. The bill also extends the requirement to health insurance policies that provide single service ancillary health coverage (e.g., dental, vision, or prescription drug coverage).

EFFECTIVE DATE: October 1, 2013

§ 16—SURETY BAIL BOND AGENT EXAMINATION ACCOUNT

PA 11-45 created the surety bail bond agent examination account as a separate, non-lapsing account in the Insurance Fund. The bill requires any funds remaining in the account at the end of each calendar year to be transferred to the General Fund. Current law transfers the funds at the end of each fiscal year.

§§ 17-18—THIRD PARTY ADMINISTRATORS

By law, the Insurance Department licenses and regulates third-party administrators (TPA). Under current law, a TPA is generally one who directly or indirectly underwrites; collects premiums or charges; or adjusts or settles claims on Connecticut residents with respect to life, annuity, or health coverage offered or provided by an insurer. The bill expands the definition of TPA by removing the limitation that coverage be offered or provided by an insurer. Thus, a TPA could be acting on behalf of a self-insured plan.

Current law exempts from the TPA licensing requirement a licensed insurer that underwrites, collects premiums or charges, or adjusts or settles claims, except for its policyholders, subscribers, and certificate holders. The bill instead specifies that a licensed insurer that also acts as a TPA is exempt from the TPA licensing requirement, but only if its activities are limited to life, annuity, or health coverage for which it is licensed. By law, such insurers must (1) be subject to the Connecticut Unfair Insurance Practices Act, (2) respond to all complaint inquiries

from the Insurance Department within 10 days after receiving them, and (3) obtain a customer's prior written consent for advertising mentioning the customer.

Under the law, the insurance commissioner does not have authority to regulate a self-insured plan subject to the federal Employee Retirement Income Security Act (ERISA). But the law specifies that the commissioner is authorized to regulate activities an insurer undertakes for such self-insured plans that do not relate to the health benefit plan and that comport with his authority under ERISA to regulate the business of insurance. The bill clarifies that the commissioner is authorized to regulate the insurer's activities when it is acting as a TPA.

§ 19—SURPLUS LINES BROKERS

By law, the insurance commissioner must maintain, publish, and make available to surplus lines brokers, a list of insurance lines that are unavailable from licensed insurers. Licensed surplus lines brokers and their clients who procure insurance that is not on the commissioner's list must file with the commissioner an affidavit showing they made diligent efforts to obtain the insurance from a licensed insurer.

The bill requires the affidavit to be filed electronically on the first day of February, May, August, and November in each year. Under current law, the affidavits are due to the commissioner within 45 days after procuring the insurance.

§ 20—LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

The bill specifies that policies providing benefits pursuant to Medicare Parts C or D are not covered by the Connecticut Life and Health Guaranty Association.

BACKGROUND

Related Bill

sHB 6379, favorably reported by the Insurance and Real Estate Committee, makes the same change as in § 19 of this bill. sHB 6379

also requires a signed statement, instead of an affidavit, eliminating a notary requirement; requires the statement to include specified information; and defines "diligent effort" to mean the surplus lines broker received at least six declinations from authorized insurers.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 18 Nay 0 (03/19/2013)